STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155661	A. BUILDING 00 B. WING	06/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWEN VALLEY HEALTH CAMPUS	920 W HWY 46 SPENCER, IN47460

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F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: June 13, 14, 15, 16, 17, 2011 Facility Number: 010892 Provider Number: 155661 AIM Number: 200229560 Survey Team: Mary Weyls, RN- TC (June 13, 15, 16, 17, 2011) Teresa Buske, RN Laura Brashear, RN Census Bed Type: SNF/NF: 99 SNF: 4 Total: 103 Census Payor Type: Medicare: 10 Medicaid: 73 Other: 20 Total: 103 Sample: 21 Supplemental Sample: 8 These deficiencies also reflect state findings cited in accordance with 410 IAC	F0000	The submission of this plan of correction does not indicate an admission by Owen Valley Health Campus (the facility) that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of Owen Valley Health Campus. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner.The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities(for title 18/19 programs).To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is this submitted as matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	16.2 Quality review completed on June 23, 2011 by Bev Faulkner, RN			
F0164 SS=D	The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and record review, the facility failed to provide personal privacy to 1 of 4 residents reviewed in a	F0164	what corrective actions will be accomplished for those residents found to have been affected by the deficient	07/17/2011

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	sample of 21 observed receiving activities of daily living care. [Resident #35] Finding includes: During initial tour with LPN # 10 on 6/13/11 at 11:50 a.m., Resident #35 was identified as having had a recent fall with fracture and utilized a Foley catheter. The resident was observed in bed. On 6/14/11 at 2:30 p.m., CNAs #5 and #6 were observed to provide catheter care to Resident #35. The resident was observed in bed with the privacy curtain not pulled around the resident's bed. The resident was observed to be exposed from the breast area down. During the care, the CNAs were observed to go to the bathroom during the care to wash their hands and to leave the resident exposed with out providing covering to the lower body. On 6/16/11 at 11:30 a.m., upon entering the resident's room, CNAs #1 and #2 were observed assisting the resident to dress. The resident was observed sitting on the edge of the bed, partially dressed. The privacy curtain was not pulled around the resident's bed. While dressing the resident, two therapy staff were observed to enter the resident's room to assist with		practice:Resident #35 will be included in random audits (attachment #2) conducted by DHS/Designee three times weekly X 4 weeks to ensure resident privacy.how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:All residents have the potential to be affected by same alleged deficient practice ,therefore, through the system changes statedbelow those residents will be ensured privacy during care.Unit Manager made rounds immediately to ensure the privacy was unbreached for all Health Care residents. No privacy issues were found.During daily rounds Unit Manager will observe and/or interview at least one resident for breach of privacy issues. Unit Manager will document response on daily round sheet.what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:A Mandatory in-service (attachment #1) will be conducted with all nursing staff on Privacy during care.During daily rounds Unit Manager will observe and interview at least one resident for breach of privacy issues. Unit Manager will document response on daily round sheet (attachment #7).how the corrective actions will be monitored to ensure the deficient practice will not recur, ie,	

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	the transfer. Resident #35's clinical record was reviewed on 6/14/11 at 10:25 a.m. A Minimum Data Set [MDS] assessment, completed on 6/9/11, coded the resident as requiring extensive assistance of two for transfer. A facility policy titled "Bill of Resident Rights," dated 10/2004, included, but was not limited to, "Privacy and Confidentiality: 17. You have the right to personal privacy...Personal privacy includes privacy in accommodations, medical treatment ...personal care..." 3.1-3(p)(4)		what quality assurance program will be put into place:Random audits (attachment #2) will be conducted per DHS/designee three times weekly X 4 weeks to ensure resident privacy during care.All audits, interviews and observations from the daily round sheets will be monitored and trended for compliance during monthly QA meetings for a minimum of 6 months or until issue resolved.	

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to protect residents with allegations of mistreatment for 2 of 2 residents reviewed with concerns of mistreatment from a CNA in a target	F0225	what corrective actions will be accomplished for those residents found to have been affected by the deficient practice: CNA #9 was suspended on 5/25/2011 pending an	07/17/2011

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	sample of 21. Resident #33 alleged CNA #9 touched her breast and Resident #104 alleged CNA #9 asked her embarrassing questions and made her feel uncomfortable, and the CNA was allowed to stay in the facility until the end of the CNA's shift and entered the resident's room after they voiced their concerns. (Resident #'s 33 and 104) (CNA#9) Findings include: During review of a "Fax / Incident Report" provided by the Administrator on 6/17/11 at 10 a.m., documentation indicated on 5/25/11 "at approximately 5:30 p.m.," two residents (Resident #'s 33 and 104) voiced complaints of feeling uncomfortable with statements made by CNA #9. The documentation indicated that Resident #104 "reported that during a Code Black situation after the CNA was instructed that she and [Resident #33] did not want him caring for them, the CNA kept bothering her..." Under the title of "Immediate Action Taken" documentation indicated, but was not limited to, "Initially both residents denied being afraid of the employee and requested to just ask the [CNA] not to come into their room or care for them. [CNA#9] was immediately informed of this and was not observed around the two residents or their room."		investigation and was terminated 5/31/2011 Residents #33 and #104 was immediately assessed per interview by Charge Nurse. Both residents stated they were not afraid they found his questions strange and made them feel uneasy and requested he no longer provide care to them. Social Service Director interviewed resident #33 and #104 on 5/26/11 and at that time resident #33 stated she was fearful because her roommate resident #104 was discharging and she was afraid to be alone at night if CNA#9 was working that hall. Social Service Director reassured resident#33 that CNA#9 would no longer be providing care. Resident was calmer. Resident #104 had no fears but was apprhensive for her roommate, Social Service Director reassured resident #104 that CNA #33 would not be providing care. Member of Nursing Management team interviewed five alert and oriented residents were interviewed to determine if they had any negative interactions with CNA#9. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the same alleged deficient practice therefore	

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	During review of a "Complaints/Investigation related to [CNA #9]" provided by the Administrator on 6/17/11 at 10 a.m., documentation indicated "On 5/25/11 at approximately 5:30 p.m.," two residents (#33 and 104) voiced a concern to employee [LPN #3], concerning CNA #9. The documentation indicated CNA #9 had been asking weird questions and would stand looking around room. The documentation indicated the "questions made Resident #104 uneasy." The documentation indicated Resident #33 "complained that she was walking out of the bathroom and he came up behind her and grabbed her breast, when asked about how he grabbed her breast she stated he had gone to help her and he rubbed up against her breast. Neither lady stated that they were afraid of the employee but did request that he not work with them any longer. [Resident #104] also requested that her money, credit card and debit card be secured in the DHS (Director of Health Services) office as the business office was closed. All items were secured in the presence of the DHS and LPN #3. [CNA #9] was immediately informed, by [LPN #3] of the request and informed him that he was to not go into the resident room and that care for the two ladies would need to be done by another [CNA]. [CNA #9] voiced		through the systemic changes stated below will ensure the campus will provide a safe environment. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Director of Health Services will be re-educated on Abuse Policy and Procedure (attachment #3) per Executive Director. Social Service/Designee will interview a minmum of two alert and oriented residents per week x 6 months during resident first meetings to ensure residents have no concerns regarding negatrive interactions with nursing staff. Social Service Director/designee will chart response of these residents on Resident First Notes and fill out resident concern form and give to DHS. Any negative responses will be reported immediately to ED/Designee for immediate follow-up. Follow-up will be documented on Resident Concern Form. how the corrective actions will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place: All facility staff will be in-serviced on the facility's Abuse and Neglect Policy and Procedure (attachment #3) upon hire and twice year Divisional Clinical Support Nurse	

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	understanding...." During interview of LPN #3 on 6/17/11 at 10:55 a.m., the LPN indicated that on 5/25/11, approximately around 5:30 p.m., the LPN entered Resident's #33 and 104's room to deliver their supper tray. The LPN indicated the residents had voiced concerns about CNA #9. The concerns were that the CNA had touched Resident#33's breast, had asked several questions of Resident #104 which made both residents uncomfortable and had indicated he had a 5 gallon bucket enema for Resident #104. LPN #3 indicated Resident #104 was uncomfortable because he was looking around the room, and requested the LPN to take her money, credit card and debit card to lock up. LPN #3 indicated she took Resident #104's money and cards to the DNS's (Director of Nursing Service) office and reported to the DNS the residents concerns. The LPN indicated she was instructed to tell CNA #9 to stay out of Resident #33 and 104's room. The LPN indicated the CNA worked the rest of his shift (until 6:30 p.m.). The LPN indicated CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m. During interview of Resident #33 on 6/17/11 at 11:20 p.m., the resident		will be notified immediately by ED/DHS of any allegations of abuse so that she/he may review to ensure compliance of facility's Abuse and Neglect Policy and Procedure. ED/Designee will review all resident Concern forms at monthly QA meeting for a minimum of 6 months or until issues resolved.	

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	indicated she and her roommate had a concern with CNA #9. The resident indicated the day the incident happened was on the day the facility was under a tornado warning and the residents had reported their concerns to the nurse prior to the tornado warning. The resident indicated she was in the bathroom and CNA#9 opened the bathroom door without knocking, the resident indicated it was a good thing she was dressed. The resident indicated the CNA #9 was assisting her out of the bathroom while she was utilizing her walker and he touched her breast. The resident indicated she felt the CNA could have kept his hands lower. The resident indicated that same morning, CNA #9 asked her roommate (Resident #104) a lot of silly questions such as if [Resident 104] had Alzheimer's, if she ever acted like a frog or drank out of a toilet. Resident #33 also indicated CNA #9 made a comment to Resident #104 about having a 5 gallon bucket enema for her. The resident indicated she and her roommate told LPN #3 about the incidents and ask that the CNA not be allowed to come back into their room. The resident indicated that after reporting the incident, CNA #9 came back to their room three times to apologize to them. During interview of the Administrator on			

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	6/17/11 at 1 p.m., the Administrator indicated the facility had implemented a tornado warning procedure on 5/25/11 around 6 p.m. The Administrator indicated CNA #9 should have been clocked out when LPN #3 brought the resident's allegations to the DNS. Upon review of CNA #9's time sheet, received on 6/17/11 at 11:10 a.m., from the Corporate RN, documentation indicated the CNA clocked out at 6:32 p.m. Resident #33's clinical record was reviewed on 6/17/11 at 11:20 a.m. An initial assessment, dated 4/30/11, indicated the resident was cognitively intact and the resident required assist of one with transfers, ambulation and dressing. Resident #104's discharged clinical record was reviewed on 6/17/11 at 12:45 p.m. The admission record indicated the resident was admitted on 2/29/11 and discharged on 5/27/11. An initial assessment was noted, dated 5/6/11, indicated the resident was cognitively intact and required assist with activity's of daily living (ADL) due to a			

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	recent fracture right humerus. 3.1-28(d)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their policy and procedure concerning protection of residents for 2 of 2 residents with concerns of mistreatment from CNA #9 in a target sample of 21 in that the CNA was allowed to stay in the facility after the concerns were voiced to a staff person, and the CNA in question re-entered the residents room. (Resident #33 and Resident #104) Findings include: During review of a "Fax / Incident Report" provided by the Administrator on 6/17/11 at 10 a.m., documentation indicated on 5/25/11 "at approximately 5:30 p.m.," two residents (Resident #'s 33 and 104) voiced complaints of feeling uncomfortable with statements made by CNA #9. The documentation indicated that Resident #104 "reported that during a Code Black situation after the CNA was instructed that she and [Resident #33] did	F0226	what corrective actions will be accomplished for those residents found to have been affected by the deficient practice:CNA #9 was suspended on 5/25/2011 and was terminated 5/31/11Residents #33 and #104 was immediately assessed per interview by Charge Nurse. Both residents stated they were not afraid they found his questions strange and made them feel uneasy and requested he no longer provide care to them.Social Service Director interviewed resident #33 and #104 on 5/26/11 and at that time resident #33 stated she was fearful because her roommate resident #104 was discharging and she was afraid to be alone at night if CNA#9 was working that hall. Social Service Director reassured resident#33 that CNA#9 would no longer be providing care.Resident was calmer. Resident #104 had no fears but was apprhensive for her roommate, Social Service Director reassured resident #104 that CNA #33 would not be providing care.Member of	07/17/2011

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	not want him caring for them, the CNA kept bothering her..." Under the title of "Immediate Action Taken" documentation indicated, but was not limited to, "Initially both residents denied being afraid of the employee and requested to just ask the [CNA] not to come into their room or care for them. [CNA#9] was immediately informed of this and was not observed around the two residents or their room." During review of a "Complaints/Investigation related to [CNA #9]" provided by the Administrator on 6/17/11 at 10 a.m., documentation indicated "On 5/25/11 at approximately 5:30 p.m.," two residents (#33 and 104) voiced a concern to employee [LPN #3], concerning CNA #9. The documentation indicated CNA #9 had been asking weird questions and would stand looking around room. The documentation indicated the "questions made Resident #104 uneasy." The documentation indicated Resident #33 "complained that she was walking out of the bathroom and he came up behind her and grabbed her breast, when asked about how he grabbed her breast she stated he had gone to help her and he rubbed up against her breast. Neither lady stated that they were afraid of the employee but did request that he not work with them any longer. [Resident #104]		Nursing Management team interviewed five alert and oriented residents were interviewed to determine if they had any negative interactions with CNA#9.how other residents having the potential to be affeced by the same deficient practice will be identified and what corrective actions will be taken:All residents have the potential to be affected by the same alleged deficient practice therefore through systemic changes stated below will ensure the campus will provide a safe environmentwhat measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Director of Health Services will be re-educated on Abuse and Neglect Policy and Procedure (attachment #3) per Executive Director.Social Service/Designee will interview a minmum of two alert and oriented residents per week x 6 months during resident first meetings to ensure residents have no concerns regarding negatrive interactions with nursing staff. Social Service Director/designee will chart responseof these residents on Resident First Notes and fill out resident concern form and give to DHS. Any negative responses will be reported immediately to ED/Designee for immediate follow-up. Follow-up will be documented on Resident	

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	also requested that her money, credit card and debit card be secured in the DHS (Director of Health Services) office as the business office was closed. All items were secured in the presence of the DHS and LPN #3. [CNA #9] was immediately informed, by [LPN #3] of the request and informed him that he was to not go into the resident room and that care for the two ladies would need to be done by another [CNA]. [CNA #9] voiced understanding...." During interview of LPN #3, on 6/17/11 at 10:55 a.m., the LPN indicated that on 5/25/11, approximately around 5:30 p.m., the LPN entered Resident's #33 and 104's room to deliver their supper tray. The LPN indicated the residents had voiced concerns about CNA #9. The concerns were that the CNA had touched Resident #33's breast, had asked several questions of Resident #104 which made both residents uncomfortable and had indicated he had a 5 gallon bucket enema for Resident 104. LPN #3 indicated Resident #104 was uncomfortable because he was looking around the room, and requested the LPN to take her money, credit card and debit card to lock up. LPN #3 indicated she took Resident #104's money and cards to the DNS's (Director of Nursing Service) office and reported to the DNS the residents concerns. The LPN		Concern Form.how the corrective actions will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place:All facility staff will be in-sevice on the facility's Abuse and Neglect Policy and Procedure (attachment #3) upon hire and twice yearlyDivisional Clinical Support Nurse will be notified immediately by ED/DHS of an allegations of abuse so that she/he may review to ensure compliance of facility's Abuse and Neglect Policy and ProcedureED/Designee will review all resident Concern forms at monthly QA meeting for a minimum of 6 months or until issues resolved.	

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	indicated she was instructed to tell CNA #9 to stay out of Resident #33 and 104's room. The LPN indicated the CNA worked the rest of his shift (until 6:30 p.m.). The LPN indicated CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m. During interview of Resident #33 on 6/17/11 at 11:20 p.m., the resident indicated she and her roommate had a concern with CNA #9. The resident indicated the time frame to be on the day the facility was under a tornado warning. The resident indicated she was in the bathroom and CNA#9 opened the bathroom door without knocking, the resident indicated it was a good thing she was dressed. The resident indicated the CNA #9 was assisting her out of the bathroom while she was utilizing her walker and he touched her breast. The resident indicated she felt the CNA could have kept his hands lower. The resident indicated that same morning, CNA #9 asked her roommate (Resident #104) a lot of silly questions such as if [Resident 104] had Alzheimers, if she ever acted like a frog or drank out of a toilet. Resident #33 also indicated CNA #9 made a comment to Resident #104 about having a 5 gallon bucket enema for her. The resident indicated she and her roommate			

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	told LPN #3 about the incidents and asked that the CNA not be allowed to come back into their room. The resident indicated that after reporting the incident, CNA#9 came back to their room three times to apologize to them. During interview of the Administrator on 6/17/11 at 1 p.m., the Administrator indicated the facility had implemented a tornado warning procedure on 5/25/11 around 6 p.m. The Administrator indicated CNA #9 should have been clocked out when LPN #3 brought the residents' allegations to the DNS. Upon review of CNA #9's time sheet, received on 6/17/11 at 11:10 a.m., from the Corporate RN, documentation indicated the CNA clocked out at 6:32 p.m. Resident #33's clinical record was reviewed on 6/17/11 at 11:20 a.m. An initial assessment, dated 4/30/11, indicated the resident was cognitively intact and the resident required assist of one with transfers, ambulation and dressing. Resident #104's discharged clinical record was reviewed on 6/17/11 at 12:45 p.m.			

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	The admission record indicated the resident was admitted on 2/29/11 and discharged on 5/27/11. An initial assessment was noted, dated 5/6/11, indicated the resident was cognitively intact and required assist with activity's of daily living (ADL) due to a recent fracture right humerus. During review of a facility policy titled, "ABUSE AND NEGLECT" received on 6/13/11 at 1:30 p.m., from the Administrator, documentation indicated under the heading of "Protection" of "Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident and the person reporting to maintain anonymity as reasonable and necessary. This may include, but is not limited to the following: .... iii. Providing 1:1 monitoring, as appropriate iv. Suspend suspected employee(s) pending outcome of investigation." 3.1-28(a)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			

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	Based on observation, record review and interview, the facility failed to ensure services were provided in accordance with each resident's plan of care in that 1 of 2 residents with plans of care to pad side rails were observed not to have the side rails padded in a sample of 21. (Resident #60) Findings include: 1. On 6/13/11 at 11:15 a.m., Resident #60's bed was observed not to have the 1/2 side rails padded. On 6/15/11 at 10:30 a.m., 2:55 p.m. and 4 p.m., the 1/2 side rails were observed not to be padded on Resident #60's bed. On 6/16/11 at 10:30 a.m., the 1/2 side rails on Resident #60's bed were observed not to be padded. Interview of the Director of Health Services (DHS) on 6/16/11 at 4 p.m., indicated the resident's side rails should have been padded. Review of the clinical record of Resident #60 on 6/14/11 at 11:20 a.m., included a plan of care addressing the problem of at risk for fall/injury as exhibited by history of falls and potential for fall dated 3/7/10 and revised 4/11. The approached included but were not limited to 1/2 side rails as enabler and padded for seizure precaution.	F0282	what corrective actions will be accomplished for those residents found to have been affected by the deficient practice:Resident #60 side-rails were padded immediately per care plan for seizure precautions.All residents with seizure precautions had careplans reviewed with in 24 hours to ensure services were provided according to established care plan.how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:All residents have the potential to be affected by the alleged deficient practice, therefore, the systemic changes stated below will ensure campus will provide a safe environment.what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:Unit Manager/Designee will audit (attachment #2) residents having padded side-rails during daily rounds 3 times weekly x 4 weeks to ensure compliance with care plan.how the corrective actions will be monitored to ensure the deficient practice will not recur:MDS will audit and update resident care plans quarterly to ensure resident care-plan are accurate and interventions are appropriate.Audits will be reviewed monthly for a minimum of six months during QA committee meeting or until	07/17/2011

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	3.1-35(g)(2)		non-compliant issue resolved.	
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review, the facility failed to secure, and position indwelling urinary catheters to prevent urinary tract infections for 3 of 3 residents reviewed with indwelling urinary catheters in a sample of 21. [Residents #34, #35, and #53] Findings include: 1. During initial tour on 6/13/11 at 11:50 a.m., with LPN #10 Resident #35 was observed in bed with an indwelling Foley catheter. The tubing was observed to be in contact with the carpeted floor. On 6/14/11 at 9:55 a.m., the resident was observed in bed and the catheter tubing was observed in contact with the floor. On 6/14/11 at 2:30 p.m., CNAs #5 and #6	F0315	what corrective actions will be accomplished for those residents found to have been affected by the deficient practice:DHS/Designee will coached and re-educated LPN #10, CNA's #5,1,2 on Guidelines for Urinary Catheter Care .Residents #34, 35 and 53 will be included in random audits(attachment #2) conducted by the ADHS/Designee 3 times weekly x4 weeks to ensure proper placement and positioning of urinary catheter bag and catheter tubing as per facility policy and procedure.Resident's #34, 35 and 53 were asssessed and found to be free at this time of Signs/symptons of UTI.how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:All residents	07/17/2011

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	were observed to provide catheter care to Resident #35. The catheter was observed not to be secured to the resident to prevent friction to the insertion site. The drainage tubing was observed to be in contact with the floor during the resident's care. CNA #5 asked if the tubing should go over or under the resident's leg and indicated she needed to look that up. On 6/16/11 at 11:30 a.m., upon entering the resident's room, CNAs #1 and #2 were observed to be assisting the resident to dress. The resident was observed sitting on the edge of the bed and the Foley catheter tubing and drainage bag were stretched out on the floor. On 6/16/11 at 5:30 p.m., the resident was observed seated in a wheelchair in the main dining room. The urinary drainage tubing was observed in contact with the floor. Resident #35's clinical record was reviewed on 6/14/11 at 10:25 a.m. The most recent Minimum Data Set [MDS] assessment, completed on 6/9/11, coded the resident as non-ambulatory, required extensive assistance of two for bed mobility and transfers and utilized an indwelling Foley catheter. 2. On 6/13/11 with LPN #10, which		in the facility with foley catheters have the potential to be affected by the alleged deficient practice.ADHS/Designee will conduct random audits (attachment #2) 3 times weekly x4 weeks to ensure residents with foley catheters have proper placement of Urinary catheter bags and catheter tubing.what measures will be put into place or what systemic changes will be made to ensure that the deficient practive does not recur:A mandatory in-service will be conducted for all nursing staff on Guidelines for Urinary Catheter care (attachment #4). ADHS/Designee will conduct random audits (attachment #2) 3 times weekly x4 weeks to ensure residents with foley catheters have proper placement of Urinary Catheter bags and Catheter tubing.how the corrective actions wll be monitored to ensure the deficient practice will recur:All audits conducted on Foley Catheter Care will be monitored in QA committee meeting monthly x 4 weeks or until non-compliance issue resolved. ADHS/Designee will review and trend monthly infection control logs for UTI's in residents with foley catheters. ADHS/Designee will report findings at monthly QA meeting x 6 months.	

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	began at 11:50 a.m. Resident #53 was observed in bed with two full side rails and with an indwelling Foley Catheter. On 6/14/11 at 11:00 a.m., the resident was observed in bed with the side rails in the raised position and the catheter drainage tubing, containing urine, was observed over the top of the side rail. Resident #53's clinical record was reviewed on 6/15/11 at 10:45 a.m. A plan of care, dated 11/24/10, addressed the problem of Alteration in Urinary Elimination as evidenced by indwelling catheter, dated 6/1/11. Interventions included, but were not limited to "Maintain F/C [Foley catheter] as ordered by MD [medical doctor] Cath care every shift, check patency F/C every shift." 3. On 6/13/11, during initial tour with LPN #10, which began at 11:50 a.m., Resident #34 was identified as being on hemodialysis. On 6/15/11 at 12:45 p.m., the resident was observed in a wheelchair in the Main Dining Room during lunch. The urinary drainage catheter was observed positioned under the seat of the chair and the drainage tubing was observed to be in contact with the floor.			

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	On 6/16/11 at 5:30 p.m., the resident was observed in the Main Dining Room during the supper meal, seated in the wheelchair, and with the urinary drainage tubing in contact with the floor. Resident #34's clinical record was reviewed on 6/16/11 at 12:05 p.m. An admission date was noted of 6/10/11. A plan of care addressed alteration in urinary elimination as evidenced by indwelling catheter. Interventions included, but were not limited to, "Change foley catheter per physician orders. Keep foley tubing free of kinks and avoid tension on urinary meatus. Provide catheter care with soap and water every shift. Maintain drainage bag below level of bladder. ..." A facility policy titled "Guidelines for Urinary Catheter Care," [no date] provided by the Corporate RN on 6/17/11 at 4:00 p.m., included, but was not limited to: "4. The urinary drainage bag should be held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. ...11. Be sure the catheter tubing and drainage bag are kept off the floor. 14. Ensure the catheter remains secured. A leg strap may be used to reduce friction and movement at the insertion site. (Note: Catheter tubing			

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	should be strapped to the resident's inner thigh.)" 3.1-41(a)(2)			
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the residents' safety for 4 of 7 residents either utilizing mechanical lifts for transfers and/or alarms to help prevent falls in a sample of 21 in that lifts were not utilized per manufacturers' recommendation and personal alarms were not applied correctly. (Resident #'s 51, 56, 78, 60) (CNA #'s 5, 6, 7, 8, 12, 13) Findings include: 1. On 6/15/11 at 12:40 p.m., CNA #'s 12 and 13 transferred Resident # 78 from a wheelchair to the bed utilizing a "Maxi Move" lift. During the transfer, the CNAs kept the legs of the lift open wide, and when approaching the bed, hit one leg on	F0323	what corrective actions will be accomplished for those residents found to have been affected by the deficient practice:ADHS/designee will re-educate CNA #'s 5, 6, 7, 8, 12 and 13 on proper procedure for use of mechanical lift according to manufacture guidelines (attachment #5). DHS/Designee will assess resident #60 for alarm reduction secondary to resident disconnects alarm independently.Residents #'s 51, 56, and 78 will be included in random audits(attachment #5) conducted by ADHS/Designee 3 times weekly x4 weeks to ensure transfer technique per manufacturer's guidelines being utilized.how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:All residents	07/17/2011

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	recliner in the room and one of the lift legs on the wheel of the bed, causing the sling the resident was sitting in to swing back and forth.		who utilize the mechanical lift for transfers and all residents who utilize bed and chair alarms for safety have the potential to be affected by this alledgd deficient practice, therefore through the systemic changes stated below thos residents will be ensured a safe environment.what measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:ADHS/Designee will in-service (attachment #5) with return demonstrations all nursing staff on proper technique in using the mechanical lift per manufacturer's guidelines. how the corrective actions will be monitored to ensure the deficient practice will not recur:All audits will be reviewed at monthly QA meeting x 2 months or until compliance is achieved.Unit Manager/Designee will conduct random audits (attachment 2) three times weekly x 4 weeks on residents who utilize a bed/chair alarm to ensure alarm properly placed and functioning.Unit Manager/Designee will conduct random audits(attachment #6) three times a week x 4 weeks to ensure staff is following manufacturer's guidelines in transfering residents who utilize the mechanical lift.ADHS/Designee will perfom a mechanical check -off upon hire and annually to ensure all nursing safe proficient with the	

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	2. On 6/14/11 at 3 p.m., Resident # 56 was observed to be transferred from the geri chair to the bed utilizing the "Maxi Move" mechanical lift by CNAs #7 and #8. The resident was observed to be lifted off the surface of the chair 18 inches. The resident remained in the high height position throughout the transfer. The resident was 18 inches off the surface of the mattress prior to being lowered. The resident was at a height above normal chair level. Review of the clinical record of Resident #56 on 6/14/11 at 2:40 p.m., indicated the most recent Minimum Data Set (MDS) assessment was completed 5/8/11. The MDS identified the resident as requiring extensive assistant of two for transfers. Nursing assessment, dated 6/8/11, indicated use of mechanical lift for transfers. 3. On 6/14/11 at 11:30 a.m., CNAs #5 and #6 were observed to transfer Resident #51 from the bed to wheelchair with the Arjo Maxi Move mechanical lift. After positioning the resident on the sling, the resident was raised from the surface of the bed. The base of the lift was observed with the legs of the lift in the closed position while raising the resident. The		mechanicalift per manufacturer's guidelines.	

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	legs of the lift were then opened and the lift with the resident was pulled away from the bed. The resident was observed in a recumbent position, perpendicular to the mast, and was transferred across the room to the wheelchair. The resident was then raised into a sitting position, turned toward the mast, and the base of the lift positioned around the wheelchair. The resident was then lowered into the chair. Resident #51's clinical record was reviewed on 6/17/11 at 4:10 p.m. The residents Minimum Data Set [MDS] with assessment reference date of 4/4/11, coded the resident as requiring total assistance of two for transfers and non-ambulatory. Review of manufacturer's operating and product care instructions for the "ARJO MAXI MOVE" the following documentation was noted, but not limited to, " Always transfer patients with the chassis legs in the closed position..... Before transferring, position the patient to face the attendant at approximately the height of a normal chair. This provides a measure of confidence and dignity to the patient..... When lowering the patient back down, lower the positioning handle to put the patient into a sitting position: This avoids further lifting strain...."			

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	4. On 6/13/11 at 11:15 a.m., Resident # 60 was observed to have a personal pressure alarm while in bed. The alarm box was hanging on the bed frame within reach of the resident. On 6/15/11 at 10:30 a.m., Resident #60 was observed lying in bed utilizing a personal pressure alarm. The alarm box was observed to be in reach of the resident. On 6/15/11 at 2:55 p.m., the connection wire to the personal pressure alarm box was observed to be disconnected from the box and lying on the floor. The resident was observed in the bed sleeping. At 4 p.m., the connection wire remained disconnected from the alarm box and remained on the floor. During interview of LPN #11 on 6/15/11 at 4 p.m., the nurse indicated the resident probably disconnected the alarm cord from the box and he has a history of doing that due to not liking the sound of the alarm. Review of the clinical record of Resident #60 on 6/14/11 at 11:20 a.m., indicated the most recent Minimum Data Set (MDS) assessment was completed 4/22/11. The assessment identified the resident with long and short term memory problem, and history of falls. The resident's most recent fall was noted as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155661	A. BUILDING 00 B. WING	06/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWEN VALLEY HEALTH CAMPUS	920 W HWY 46 SPENCER, IN47460

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	3/11/11. The resident's current plan of care addressed the problem of at risk for fall/injury as exhibited by history of falls and potential for fall dated 3/7/10 and revised 4/11. The approaches included but were not limited to utilize bed alarm-check placement and function every shift. Review of the "Deluxe Attendant Pressure Pad Alarm" on 6/17/11 at 4:20 p.m. indicated "...Place monitor out of reach of the resident. Suitable mounting locations include: back of headboard, back of wheelchair, wall or under the bed. Make sure that the resident cannot tamper with monitor or reach the 'Reset' button..." 3.1-45(a)(2)			